

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044122

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10906

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 1 month	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		d. STREET ADDRESS (If outside, give location) #50 Plaza Square	
3. NAME OF DECEASED (Type or print) First Middle Last LEWIS ALLEN DAVIES		4. DATE OF DEATH Month Day Year Nov 10 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/11/1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired President		10b. KIND OF BUSINESS OR INDUSTRY Davies Supply & Mfg Co	
13a. FATHER'S NAME David Davies		13b. MOTHER'S MAIDEN NAME Anna Allen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. HH 11	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BASILAR ARTERY THROMBOSIS DUE TO (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) HYPERTENSION (essential) 332XH Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		14. NAME OF HUSBAND OR WIFE Frances Davies	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CARCINOMA ORAL TO AT NECK.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 9/61 to 11/10/62 and last saw her alive on 8 AM 10/10/62 Death occurred at 11 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) H. M. Davis M.D.		22b. ADDRESS 114 N. Taylor Ave St. Louis	
22c. DATE SIGNED 11/14/62		22d. DATE RECD. BY LOCAL REG. 11/13/62	
23a. BURIAL, CREMATION, REMOVAL, (Specify) Cremation		23b. DATE 11/13/62	
23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory		23d. LOCATION (City, town, or county) (State) St. Louis Mo	
24. FUNERAL DIRECTOR Bopp Chapel		25. DATE RECD. BY LOCAL REG. 11/13/62	
26. REGISTRAR'S SIGNATURE H. M. Davis		27. REGISTRAR'S SIGNATURE H. M. Davis	

USE BLACK INK
OR
TYPEWRITER RIBBON

FEB 20 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.